

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9168

CERTIFICATE OF DEATH

Reg. Dist. No.

09158

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Forest Hill</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Forest Hill</u>		
c. LENGTH OF STAY IN 1b <u>77 yrs.</u>			d. STREET ADDRESS <u>Bailey Road</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bailey Road</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hannah Bertha Baird</u>			4. DATE OF DEATH Month Day Year <u>Aug. 25, 19 61</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1883</u>		9. AGE (In years last birthday) <u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	11. BIRTHPLACE (State or foreign country) <u>Sharon, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Baird</u>			14. MOTHER'S MAIDEN NAME <u>Annie Baird</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	17. INFORMANT Address <u>Miss. Elizabeth Baird Forest Hill, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypo Static Lowbar Pneumonia due to Bronchiectasis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardio Vascular Disease.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Rheumatoid Arthritis.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Nov. 1953</u> , 19____, to <u>Aug. 24, 1961</u> , that I last saw the deceased alive on <u>Aug. 24, 1961</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Md.</u> <u>Aug. 25, 1961</u> PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u> <u>Forest Hill, Maryland.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/28/1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>William Watters</u>	22d. LOCATION (City, town, or county)	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Hunt</u> <u>Jarrettsville Md.</u>			24a. REC'D BY REGISTRAR DATE <u>AUG 28 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air			c. LENGTH OF STAY in 1b 2 months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D. Fountain Green Road.					d. STREET ADDRESS R.D. Fountain Green Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RANDOLPH Middle HAROLD Last BALL					4. DATE OF DEATH Month August Day 1 Year 19 61				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 19, 1961		9. AGE (In years last birthday) yrs. 2 Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Havre de Grace, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold P. Ball					14. MOTHER'S MAIDEN NAME Ruth Ann Suitt				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. ----		17. INFORMANT Harold P. Ball Address 410 Fountain Green Road R.D. Bel Air, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis. 492X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, } DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/1/61 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. Address (Street, city, town, or county) ACTUAL SIGNATURE <i>Charles S. Petty</i> M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 3, 1961		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens Bel Air, Harford, Md.		22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR <i>Joseph W. Foster</i> Joseph W. Foster			ADDRESS W. Broadway & Williams St. Bel Air, Maryland			24a. REC'D BY REGISTRAR DATE AUG 3 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	

2071123X03
Joseph W. Foster

FOR STATE
HEALTH DEPT.

2163

Barford

Del Air

N.A. Thompson in Green House.

Maryland

Del Air

N.A. Thompson in Green House.

BARBORA

HANCOCK

WILL

August 1

Male White

July 19, 1901

None

Barford in Green House.

Barford in Green House.

Barford in Green House.

Barford in Green House.

Barford in Green House.

X

X

Barford in Green House.

Barford in Green House.

Barford in Green House.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9170

09160

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 Aberdeen		d. STREET ADDRESS 162 East Deen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Army Hospital Aberdeen Proving Ground, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARIE JOANNE HERUE				4. DATE OF DEATH Month August Day 28 , Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1928	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME REUBEN M. CAPO				14. MOTHER'S MAIDEN NAME Sarah M. Myatt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 261-32-4488		17. INFORMANT Sarah M. Capo (Mother) Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 433.0 IMMEDIATE CAUSE (a) Cardiac Arrest due to unknown cause DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (MISSING) attended the deceased from August 28, 1961 , to August 28, 1961 , that (I) XXX saw the deceased alive on August 28, 1961 , and that death occurred 1245 PM from the causes and on the date stated above.							
22a. SIGNATURE Jimmie R. Cleary				22b. DATE August 28 1961			
22c. PHYSICIAN'S NAME (Type) JIMMIE R. CLEARY Capt MC				22d. ADDRESS U. S. Army Hospital Aberdeen Proving Ground, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 1-1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Farriey - Aberdeen Md				25a. REC'D BY REGISTRAR SEP 5 '61		25b. REGISTRAR'S SIGNATURE J. Hines	

MEDICAL CERTIFICATION

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VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Information from birth cert.

09161

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre-de-Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS Bel Air	
3. NAME OF DECEASED (Type or print) Baby Boy BILLINGS		4. DATE OF DEATH Month 8 Day 12 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 8-11-61
9. AGE (In years last birthday) 7		IF UNDER 1 YEAR Months 1 Days 1	IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY no	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Billings		14. MOTHER'S MAIDEN NAME Joyce Shuler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Charles Billings		Address Bel Air	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 7665 DUE TO (c) 7665			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Baptist View Cen		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) August 14, 1961		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City, town or county) (State) Harford Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE H & Bailey		25a. DATE AUG 16 61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank		25c. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
9172 09162											
1. PLACE OF DEATH a. COUNTY Harford MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD MEMORIAL HOSPITAL 37 Hanover St., Aberdeen, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Geraldine E. Bishop						4. DATE OF DEATH Month August Day 3 Year 1961					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 30, 1933		9. AGE (In years last birthday) 27 yrs.		10. IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min. 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY South Hill, Virginia					
11. BIRTHPLACE (County & State, or foreign country) U. S. A.						12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Willie E. Sturdivant						14. MOTHER'S MAIDEN NAME Carrie B. Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No						16. SOCIAL SECURITY NO. 229-44-5135					
17. INFORMANT Mr. Oscar A. Bishop, Jr. Aberdeen, Md.						Address 37 Hanover St.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chorionepithelioma with Metastases to the Brain. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 173X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. 19 p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 7/31 , 19 61 , to 8/3 , 19 61 that (I) (we) last saw the deceased alive on 8/3 , 19 61 , and that death occurred at 8/3 , 19 61 , from the causes and on the date stated above.											
22a. SIGNATURE George T. Stansbury, M.D.						22b. DATE 8/4/61					
22c. PHYSICIAN'S NAME (Type) George T. Stansbury						22d. ADDRESS 569 Revolution St. Havre de Grace, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal						23b. DATE THEREOF Aug. 4, 1961					
23c. NAME OF CEMETERY OR CREMATORY Figgins Funeral Home						23d. LOCATION (City, town or county) (State) South Hill, Va.					
24. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock - Havre de Grace, Md.						25a. REC'D BY REGISTRAR DATE AUG 9 '61					
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas											

(M)

9173

Hartford

Wallingford

Wallingford

Wallingford, Conn.

Wallingford, Conn.

Wallingford

Wallingford

Wallingford

Dec. 30, 1933

Dec. 30, 1933

Wallingford, Conn.

Wallingford

Wallingford

Wallingford

Wallingford

Wallingford, Conn.

Chlorophylloma with metastases to the brain.

(I)

Wallingford

Wallingford

Wallingford

Wallingford

Wallingford

Wallingford

Wallingford

1
FOR STATE
HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

9173 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09163

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. LENGTH OF STAY in lb <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrettsville</i>		d. STREET ADDRESS <i>1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Alexander Campbell</i>				4. DATE OF DEATH Month Day Year <i>August 14 1961</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 27, 1900</i>		9. AGE (In years last birthday) <i>61</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Roofer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Roofing</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Archie Campbell</i>				14. MOTHER'S MAIDEN NAME <i>Florence Scott Leslie</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes give year or dates of service) <i>410-01-6663</i>		17. INFORMANT <i>L. Archie Campbell</i>		Address <i>White Hall, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture skull</i> 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) <i>Fracture R femur Fracture Radius Crushing injury chest</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture R femur Fracture Radius Crushing injury chest</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Auto accident</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>8-12 1961</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Lake Road</i>		20f. (City or town) (County) (State) <i>Bethesda Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bethesda Md</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>8-15-61</i>							
ACTUAL SIGNATURE <i>Loren C Palmer</i>		M.D. DATE SIGNED					
EXAMINER'S NAME (Type) <i>Gerald C Palmer M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/17/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Raeform</i>		22d. LOCATION (City, town, or country) (State) <i>Raeform N.C.</i>	
23. FUNERAL DIRECTOR <i>Charles E. Kurtz</i>		ADDRESS <i>Garrettsville, Md.</i>		24a. REC'D BY REGISTRAR <i>AUG 16 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9174

CERTIFICATE OF DEATH

Reg. Dist. No.

09164

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 1, Box 69		d. STREET ADDRESS R.D. 1, Box 69	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle C. Last CHILDERS		4. DATE OF DEATH Month August Day 23 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1888
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Painter (Ret.) Farm		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Childers		14. MOTHER'S MAIDEN NAME Ellen Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-12-9758	
17. INFORMANT Mrs. J.C. Childers		Address RD. 1, Box 69 Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Hypertensive Cardio Vascular Disease. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 52 , to August , 19 61 , that I last saw the deceased alive on August 23 , 19 61 , and that death occurred at 7:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Willard P. Hudson M.D. Forest Hill, Md. Aug. 24, 1961 PHYSICIAN'S NAME (Type) Willard P. Hudson M.D. Forest Hill, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/26/61	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE AUG 28 '61	
24b. REGISTRAR'S SIGNATURE Christina S. Hanna			

John G. Tarring

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9175

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09165

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hansel Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Falls</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>Franklinville Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hanford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>A</u> Last <u>Cook</u>		4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30-1910</u>
9. AGE (In years last birthday) <u>51 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Anson R Kintner</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Middeaguh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John H Cook</u>		Address <u>Franklinville Rd Upper Falls</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Cervical vertebra</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>816X</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture skull. Fracture ribs & subcutaneous emphysema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto, auto type</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8:15</u> p.m. <u>8-18-1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>51st & Mt. St. 152</u>		20f. (City or town) <u>Fallston</u> (County) <u>Baltimore</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>8-18-61</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bel A. ...</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-22-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>		22d. LOCATION (City, town, or country) <u>Belair Maryland</u>	
23. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Road</u>	
24a. REC'D BY REGISTRAR <u>AUG 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. ...</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09166

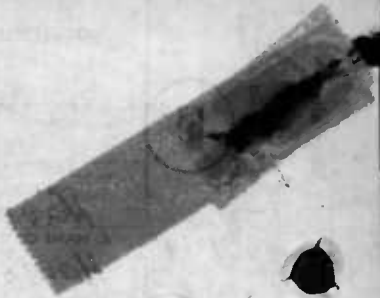
1. PLACE OF DEATH a. COUNTY <i>Hartford</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harrods Grace</i> c. LENGTH OF STAY IN 1b <i>Harrods Grace</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Hartford Memorial Hosp.</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Hartford</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Perryman</i> d. STREET ADDRESS <i>Rural # 3</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Stephen Shawn</i> First <i>CREW</i> Middle Last 4. DATE OF DEATH <i>Aug 11</i> Month <i>61</i> Day Year				5. SEX <i>Male</i> 6. COLOR OR RACE <i>Can</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>Aug 6 '61</i> 9. AGE (In years last birthday) <i>3</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i> 11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Edward Crew</i> 14. MOTHER'S MAIDEN NAME <i>Winnifred Smallwell</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> 16. SOCIAL SECURITY NO. <i>None</i> 17. INFORMANT <i>E. Crew</i> Address <i>RD 3 Aberdeen, MD</i>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i> <i>763.5</i> DUE TO (b) <i>Prematurity (7 1/2 mo gestation - 3# 14oz)</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <i>5da</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8/6/61</i> to <i>8/11/61</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>8/11/61</i> , 19 <i>61</i> , and that death occurred at <i>6:10 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Alfred W. Grigoleit</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type or print) <i>Alfred W. Grigoleit</i>				22d. ADDRESS <i>608 S. Union St. Harrods Grace, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<i>Burial</i>		<i>Aug. 14 - 1961</i>		<i>Moreland Memorial Park</i>		<i>Balto. County - Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Tarning - Aberdeen, Maryland</i> ADDRESS				25a. REC'D BY REGISTRAR <i>AUG 14 '61</i> DATE		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9177

09167

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b Unknown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital Aberdeen Proving Ground, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 622 Walker	
3. NAME OF DECEASED (Type or print) First FRANK Middle F Last DELORE				4. DATE OF DEATH Month August Day 16 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1900	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier (Retired)				10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? (Nat) USA							
13. FATHER'S NAME VICTOR DELORE				14. MOTHER'S MAIDEN NAME Adele Crauaz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 213-26-4224		17. INFORMANT Victor Delorme (Brother) Address Rt#4 Box 108 Powhatan, VA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA + CONGESTION, BILATERAL (MARKEDLY SEVERE) 522X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from August 7, 1961 to August 16, 1961 that (I) (we) last saw the deceased alive on August 16, 1961 , and that death occurred at 10aM , from the causes and on the date stated above.							
22a. SIGNATURE Casimir A. Gorczyca				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED August 16, 1961	
22c. PHYSICIAN'S NAME (Type) Casimir A. Gorczyca				22d. ADDRESS U. S. Army Hospital Aberdeen Proving Ground, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 8/24/61		23c. NAME OF CEMETERY OR CREMATORY Edgewood Center		23d. LOCATION (City, town, or county) (State) Edgewood, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring				ADDRESS Terling Funeral Home		25a. RECEIVED BY REGISTRAR AUG 22 61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09168

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Bel Air	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Samuel Last Dill		4. DATE OF DEATH Month August Day 10 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19, 1901
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equip. Operator	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew J. Dill		14. MOTHER'S MAIDEN NAME Mary M. Badders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-22-0029	
17. INFORMANT Mr. Norman Dill		Address 761 Henderson Rd., Bel Air, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4:20 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Coronary artery disease (c) ?			INTERVAL BETWEEN ONSET AND DEATH 22 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 01 p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 1960 , to August 10, 1961 , that I last saw the deceased alive on August 9, 1961 , and that death occurred at 4:20 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED Aug. 11, 1961			
ACTUAL SIGNATURE Willard P. Hudson M.D.		PHYSICIAN'S NAME (Type) WILLARD P. HUDSON M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF August 14, '61	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	22d. LOCATION (City, town, or county) (State) Bel Air, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		24a. REC'D BY REGISTRAR DATE AUG 14 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Hannon

Joseph W. Foster

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

20501P1XV2

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9179

09169

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 6hrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RHONDA DENISE DILMORE		4. DATE OF DEATH August 15 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Harford, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS Earl DILMORE		14. MOTHER'S MAIDEN NAME Linda D. Shaw	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT THOMAS EARL DILMORE (Father) same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 776X (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 6hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 15, 1961 to August 15, 1961 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on August 15, 1961 , and that death occurred at 926AM , from the causes and on the date stated above.			
22a. SIGNATURE Malcolm McLean M.D.		22b. DATE 15 August 1961	
22c. PHYSICIAN'S NAME (Type) MALCOLM MCLEAN Capt MC		22d. ADDRESS U. S. Army Hospital Aberdeen Proving Ground, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8/17/61	
23c. NAME OF CEMETERY OR CREMATORY Quincy		23d. LOCATION (City, town or county) (State) Birmingham, Alabama	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		25a. REC'D BY REGISTRAR 18 61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume		DATE	

34

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9180 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Harford</i>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harmed Lane</i>				c. LENGTH OF STAY IN 1b <i>10 yrs.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harmed Lane</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>WESLEY Westley Eastwood</i>				d. STREET ADDRESS <i>Revolution</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>WESLEY Westley Eastwood</i>				4. DATE OF DEATH Month <i>August</i> Day <i>2</i> Year <i>1961</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 12 - 1915</i>		9. AGE (In years last birthday) <i>45 yrs.</i>		10. IF UNDER 1 YEAR Months <i>4</i> Days <i>16</i> Hours <i>46</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>				11. PLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>W.W.2</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>				17. INFORMANT <i>Noa B. Eastwood</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>973</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____				Poisoning due to CO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hooked 4 into exhaust to hose in car</i>							
20c. TIME OF INJURY Month, Day, Year Hour <i>7-30</i> a.m. <i>61</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>quarry</i>		20f. (City or town) <i>Harmed Lane</i>		20g. (County) <i>Harford</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bel Air, Md</i>				DATE SIGNED <i>8-2-61</i>			
ACTUAL SIGNATURE <i>Lerald C Palmer</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <i>Gerald C Palmer - MD</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <i>8/4/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Bellini Memorial</i>		22d. LOCATION (City, town, or country) <i>Bel Air, Md.</i>		(State)	
23. FUNERAL DIRECTOR <i>Washington Pm. Harmed Lane Md.</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>AUG 3 '61</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>			

(M)

Handwritten notes and signatures, including "H. J. ...", "J. ...", and "J. ...".

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONER OF

THE DEPARTMENT OF

THE STATE

OF THE

DEPARTMENT OF

THE STATE

OF THE

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9181

Item 8 Film 6292

8/25/61

09171

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 57 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUARILLA E Middle FOARD Last FOARD		4. DATE OF DEATH Month August Day 15 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 17 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Clinton Cooper		14. MOTHER'S MAIDEN NAME MARY JEWNESS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 220-32-3134	
17. INFORMANT Edward C. Loo, M.D.		Address Haure de Grace, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) A.S.C. V.D. and senility DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Fracture of left hip ② Diverticulitis + Diverticulosis + hemorrhage			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1st, 1961 , to Aug 15th, 1961 , that (I) (we) last saw the deceased alive on Aug 15th, 1961 , and that death occurred at 11:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE Edward C. Loo, M.D.		22b. DATE SIGNED 8/16/61	
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22d. ADDRESS Haure de Grace, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Aug 19, 1961	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Bakers Cem	23d. LOCATION (City, town, or county) (State) Harford Co Md
24. FUNERAL DIRECTOR'S SIGNATURE H.S. Bailey		25a. REC'D BY REGISTRAR AUG 22 '61	
ADDRESS Harlington, Md		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9182

CERTIFICATE OF DEATH

09172

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen	
c. LENGTH OF STAY IN 1b 3 1/2 hrs		d. STREET ADDRESS RD 3 ; Box 146	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Juanita Iva Gilley		4. DATE OF DEATH Month August Day 25 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July, 9, 1917
9. AGE (in years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler		10b. KIND OF BUSINESS OR INDUSTRY Shoe	
11. BIRTHPLACE (County & State, or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Houck		14. MOTHER'S MAIDEN NAME Elizabeth Burkett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-38-8842	
17. INFORMANT Vaughn Gilley		Address Aberdeen Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None			
INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 25, 1961 to Aug 25, 1961 , that (I) (we) last saw the deceased alive on August 25, 1961 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dudley Phillips MD M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dudley Phillips MD		22d. ADDRESS Darlington, N.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF Aug. 27, 1961	23c. NAME OF CEMETERY OR CREMATORY Badgers Funeral Home	23d. LOCATION (City, town or county) (State) West Jefferson, North Carolina
24. FUNERAL DIRECTOR'S SIGNATURE Edward K. McElerns Jr		25a. REC'D BY REGISTRAR Aug 29 '61	
ADDRESS Abingdon Md.,		25b. REGISTRAR'S SIGNATURE Arthur S. Hu	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2122

(M)

(I)

ALBERT BAKER

ASSISTANT

BOSS

ELIZABETH BAKER

NO

1923-28 1892

VAUGHN GILLY

1900-1901

WYLAND

REMOVED

AUG. 27, 1904

BAGGERS FUNERAL HOME

WEST JEFFERSON, NORTH CAROLINA

WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9183

CERTIFICATE OF DEATH

09173

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> ✓															
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAUCE DE GRACE</u>		c. LENGTH OF STAY IN lb <u>6 DAYS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		07X-2													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>Rising Sun</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Jones</u> Last <u>Goss</u>				4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>1961</u>															
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-17-1909</u>													
9. AGE (In years, last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mushroom House</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NORTH CAROLINA</u>													
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>																			
13. FATHER'S NAME <u>Webster Goss</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE POWERS</u>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>156-16-2931</u>															
17. INFORMANT <u>Mrs. Paul Goss</u>				Address <u>Rising Sun, Md.</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>3 yrs</u>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> , 19 <u>61</u> , to <u>8/12</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/12</u> , 19 <u>61</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>Neil Taylor</u> M.D.								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>8/12/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr MD</u>								22d. ADDRESS <u>Rising Sun, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/16/1961</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Goss Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>West Jefferson N.C.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ermon E. McMullen</u>								ADDRESS <u>Rising Sun, Md.</u>				25a. REC'D BY REGISTRAR <u>AUG 15 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

3.2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9184

CERTIFICATE OF DEATH

Reg. Dist. No.

09174

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hayre de Grace</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Box 45 A Rt. 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Ellwood</u> Last <u>Grafton</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>24</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1883</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Chemical Center</u>	
11. BIRTHPLACE (State or foreign country) <u>Chestnut Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hall Grafton</u>		14. MOTHER'S MAIDEN NAME <u>Anna Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-22-0052</u>	
17. INFORMANT <u>Mrs. Betty Grafton</u>		Address <u>Bel Air, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia terminating Chronic Cardio Vascular</u> DUE TO (b) <u>Disease, decompensated.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mid-thigh amputation of right leg. (peripheral vascular disease)</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>48</u> , to <u>Aug.</u> , 19 <u>61</u> that I last saw the deceased alive on <u>Aug. 23</u> , 19 <u>61</u> , and that death occurred at <u>4:00pM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Willard P. Hudson M.D.</u> <u>Forest Hill, Md.</u> <u>Aug. 25, 1961</u> PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u> <u>Forest Hill, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon</u>		22d. LOCATION (City, town, or county) (State) <u>Prospect Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hunt</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 '61</u>	
ADDRESS <u>Farmingtonville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9185

Item 9 Film G293 8/31/61

09175

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. ARMY HOSPITAL Aberdeen Proving Ground, Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace d. STREET ADDRESS Rd #1, Box 64a e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MURRAY First Middle Last LAWRENCE GREY		4. DATE OF DEATH August 21 19 61 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 12, 1906 54/55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army	11. BIRTHPLACE (County & State, or foreign country) Maine
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ORVIS M. GREY	
14. MOTHER'S MAIDEN NAME MATTIE SARGENT		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW II	
16. SOCIAL SECURITY NO. 224-52-3959		17. INFORMANT Mrs. Mavis A. Grey (wife) Address Rd 1, Box 64a	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Anterior Myocardial Infarction DUE TO (c) Cornary Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 13 days 5 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from August 21, 1961 to August 21, 1961 , that (I) (we) saw the deceased alive on August 21, 1961 , and that death occurred 8:55 AM from the causes and on the date stated above.			
22a. SIGNATURE John E. Hoffman M.D.		22b. DATE SIGNED 21 Aug 61	
22c. PHYSICIAN'S NAME (Type) JOHN E. HOFFMAN Capt MC		22d. ADDRESS U. S. Army Hospital Aberdeen Proving Ground, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/24/61	23c. NAME OF CEMETERY OR CREMATORY Orlington National	23d. LOCATION (City, town or county) (State) Orlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Earl W. Robertson ADDRESS 6306 - Belton Rd, Baltimore 6, Md		25a. REC'D BY REGISTRAR NUG 28 '61	25b. REGISTRAR'S SIGNATURE Christ S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22a Film G296 8/26/61 1wk

CERTIFICATE OF DEATH

Reg. Dist. No.

03176

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 53 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Arrick Last Hall		4. DATE OF DEATH Month August Day 23 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1877
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. AGE (In years last birthday) 83 yrs.	
10a. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Joseph Arrick Harris	
14. MOTHER'S MAIDEN NAME Ellin Worthington		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mary H. Hall Address 53 Broadway, Bel Air, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage due to carcinoma of transverse colon. 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of transverse colon. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cardio Vascular Disease. 30 yrs.		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 19 38 , to Aug. 19 61 , that I last saw the deceased alive on Aug. 22, 19 61 , and that death occurred at 4:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED Aug. 23, 1961			
ACTUAL SIGNATURE Willard P. Hudson M.D. Forest Hill, Md.			
PHYSICIAN'S NAME (Type) Willard P. Hudson M.D. Forest Hill, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 25, 1961	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Episcopal Church Emmorton, Md.		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway + Williams St, Bel Air, Maryland		24a. REC'D BY REGISTRAR DATE AUG 24 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

CENTRAL FILE OF CASES

10187

10187

RECEIVED - FEDERAL BUREAU OF INVESTIGATION

U.S. DEPARTMENT OF JUSTICE

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RECEIVED - FEDERAL BUREAU OF INVESTIGATION

U.S. DEPARTMENT OF JUSTICE

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RECEIVED - FEDERAL BUREAU OF INVESTIGATION

U.S. DEPARTMENT OF JUSTICE

10187

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09178

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Maryland				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa d. STREET ADDRESS PO Box 56 Pine Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bernard Francis Hennessy				4. DATE OF DEATH August 5 1961			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Jun 1890	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Officer US Army				10b. KIND OF BUSINESS OR INDUSTRY Soldier		11. BIRTHPLACE (State or foreign country) Fitchburg, Mass	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Bernard Hennessy				14. MOTHER'S MAIDEN NAME Catherine E. Hurley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I & II				16. SOCIAL SECURITY NO. 215-42-2217		17. INFORMANT Margaret C Hennessy Address PO Box 56 Pine Road Joppa, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple pulmonary emboli DUE TO (c) Phlebothrombosis both lower extremities				INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 days Undet			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Traumatic arthritis left knee; Generalized arteriosclerosis and arteriosclerotic heart disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Arthritis due to auto accident, drove off road and struck face & knee on panel.			
20c. TIME OF INJURY Month, Day, Year 12:15 m. 17 Jul 1961		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hiway 40		20f. (City or town) Edgewood (County) Harford (State) Md	
21. I certify that (I) (this hospital) attended the deceased from 17 July 1961 to 5 Aug 1961 that (I) (we) last saw the deceased alive on 5 Aug 1961 , and that death occurred at 9:40 am from the causes and on the date stated above.							
22a. SIGNATURE Albert Frankel				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5 August 1961	
22c. PHYSICIAN'S NAME (Type) Albert Frankel				22d. ADDRESS US Army Hospital Aberdeen Proving Ground, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 11, 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) Arlington (State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCombs				ADDRESS Abingdon, Md.,		25a. REC'D BY REGISTRAR Aug 10 '61 25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

(M)

2188

CERTIFICATE OF DEATH

1917

STATE OF VIRGINIA
COUNTY OF SPOTSYLDEN
I, the undersigned, a duly qualified and authorized officer of the State of Virginia, do hereby certify that on the 1st day of January, 1917, at the City of Alexandria, in the County of Alexandria, State of Virginia, died the following named person, to-wit:
Name of Deceased: [illegible]
Age: [illegible] years
Sex: [illegible]
Color: [illegible]
Cause of Death: [illegible]
Place of Death: [illegible]
Date of Death: [illegible]
Signed and sworn to before me this [illegible] day of [illegible], 1917.
Notary Public for the State of Virginia.

Witness my hand and the seal of the State of Virginia at the City of Alexandria, this 1st day of January, 1917.
[illegible]
Notary Public for the State of Virginia.

CERTIFICATE OF DEATH

Reg. Dist. No. 09179

9189

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hitchcock Road</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural WHITE HALL</u>			
c. LENGTH OF STAY IN 1b <u>53 yrs</u>				d. STREET ADDRESS <u>HITCHCOCK ROAD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural White Hall</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Milton Clyde Hitchcock</u>				4. DATE OF DEATH Month Day Year <u>Aug 29 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 4 1894</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Shawsville Harford md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wesley Hitchcock</u>				14. MOTHER'S MAIDEN NAME <u>Emma Garrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-36-9935</u>			
INFORMANT Address <u>Rachel R. Hitchcock White Hall</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>arteriosclerosis (cerebral)</u> DUE TO (c) <u>hemiplegia (right side)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 10 1961</u> to <u>Aug. 28 1961</u> , that I last saw the deceased alive on <u>Aug. 23 1961</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman H. Gemmill</u>				ADDRESS (Street, city or town, state) <u>Stewartstown, Pa.</u> DATE SIGNED <u>Aug. 29, 1961</u>			
PHYSICIAN'S NAME (Type) <u>Norman H. Gemmill.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug-31-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ayres Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Dry Branch Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion E. Smith</u> ADDRESS <u>Intervale Rd</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 31 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

[Faint, mostly illegible text in the upper section of the certificate, likely containing personal details of the deceased.]

[Faint, mostly illegible text in the middle section of the certificate, likely containing details of the death and burial.]

[Faint, mostly illegible text in the lower section of the certificate, likely containing the signature of the official and the date.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any way is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND										2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>✓</u>																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampden</u>										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Amford Memorial Hospital</u>										d. STREET ADDRESS <u>75X-3</u>																			
3. NAME OF DECEASED (Type or print) <u>Joseph Holgate</u>										4. DATE OF DEATH <u>August 7, 1961</u>																			
5. SEX <u>M</u>										6. COLOR OR RACE <u>W</u>																			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH <u>3-19-1933</u>																			
9. AGE (In years last birthday) <u>28</u> yrs.										10. IF UNDER 1 YEAR Months <u>28</u> Days <u>7</u> Hours <u>19</u> Min. <u>61</u>																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U S Marines</u>										10b. KIND OF BUSINESS OR INDUSTRY <u>U S Armed Force. Penna.</u>																			
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>										12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>																			
13. FATHER'S NAME <u>William John Holgate</u>										14. MOTHER'S MAIDEN NAME <u>Unknown</u>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>										16. SOCIAL SECURITY NO. <u>200-24-6247</u>																			
17. <u>Korean</u>										18. <u>4th Co. 10. SER. Bn. M.C.S. Quantico, Va.</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple fractures large bones (R femur, pelvis, R humerus)</u> DUE TO (b) <u>825X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>825X</u>																				INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>A auto accident</u>																			
20c. TIME OF INJURY Month, Day, Year <u>8-6-61</u> Hour a.m. <u>8</u> p.m. <u>19</u>										20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>																			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>nd</u>										20f. (City or town) (County) (State) <u>nd</u>																			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Rel Ar, nd</u>									
22a. ACTUAL SIGNATURE <u>Gerold C Palmer</u>										22b. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
22c. EXAMINER'S NAME (Type) <u>Gerold C Palmer - MD</u>										22d. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
22e. ADDRESS (Street, city, town, or county) <u>Perryville, Md.</u>										22f. DATE SIGNED <u>8-7-61</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>& Burial</u>										22b. DATE THEREOF <u>8-9-1961</u>																			
22c. NAME OF CEMETERY OR CREMATORY <u>Beverly National Cem. Beverly, N.J.</u>										22d. LOCATION (City, town, or country) (State) <u>nd</u>																			
22e. FUNERAL DIRECTOR <u>Leva Patterson & Son,</u>										22f. ADDRESS <u>Perryville, Md.</u>																			
22g. REC'D BY REGISTRAR <u>Aug 10 '61</u>										22h. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>																			

(M)

(I)

U.S. Airman Force, Penna.
U.S.A.
William John Hofe
200-24-8267
4th Dist. U.S. Air Force, Wash. D.C.
Munich, Va.

U.S. Airman Force, Penna.
U.S.A.
William John Hofe
200-24-8267
4th Dist. U.S. Air Force, Wash. D.C.
Munich, Va.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9191

CERTIFICATE OF DEATH

09181

1. PLACE OF DEATH a. COUNTY M C O S Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen c. LENGTH OF STAY IN lb 38mins d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Army Hospital Aberdeen Proving Ground, Maryland			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De. Grace d. STREET ADDRESS 556 Franklin e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) RONALD KEITH HOLLON JR		4. DATE OF DEATH Month August Day 14 Year 19 61		5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 14, 1961	9. AGE (In years last birthday) yrs. 38	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME RONALD KEITH HOLLON SR						14. MOTHER'S MAIDEN NAME DOROTHY J. PARKINSON			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No N/A N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Address Ronald K. Hollon Sr (Father) same as #2	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (29½ weeks gestation) DUE TO (b) Prolapsed Cord DUE TO (c) Precipitous Labor PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 761-5								INTERVAL BETWEEN ONSET AND DEATH 38mins	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) August 14, 1961 to August 14, 1961, that (I) (X) saw the deceased alive on August 14, 1961, and that death occurred at 1:04 PM from the causes and on the date stated above.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE Julio B. Acosta M.D. 22c. PHYSICIAN'S NAME (Type) JULIO B. ACOSTA Capt MC						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Army Hospital Aberdeen Proving Ground, Maryland		22b. DATE SIGNED August 14, 1961	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/16/61		23c. NAME OF CEMETERY OR CREMATORY Belt Cemetery		23d. LOCATION (City, town or county) (State) Aberdeen PA, Md			
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tanning Aberdeen				25a. REC'D BY REGISTRAR DATE AUG 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krause			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9192

09182

FOR STATE HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace c. LENGTH OF STAY in 1b Harford Memorial Hospital d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Alabama b. COUNTY 40X-3 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Phoenix City d. STREET ADDRESS 1805 Crawford Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) JETTIE HOLMES		4. DATE OF DEATH Month 8 Day 9 Year 1961		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 28, 1913		9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Grammar School				11. BIRTHPLACE (State or foreign country) Lee County, Alabama				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Gerry McKessie				14. MOTHER'S MAIDEN NAME Rena Bage				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 419-50-1949 Mr. George Holmes				16. SOCIAL SECURITY NO. 1805 Crawford Ave				17. INFORMANT Phoenix City, Ala			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute massive embolism due to pelvic phlebo- thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Russell S. Fisher				M.D. RUSSELL S. FISHER, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher				Address (Street, city, town, or county) 8-10-61				DATE SIGNED 8-10-61				DATE 8-10-61				SIGNATURE Elmer E. Bullock			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 8-14-61				22c. NAME OF CEMETERY OR CREMATORY Edgar H. Battle Funeral Home				22d. LOCATION (City, town, or country) (State) 1107 Second Ave Phoenix City Alabama							
23. FUNERAL DIRECTOR Elmer E. Bullock				ADDRESS Havre de Grace, Md				24a. REC'D BY REGISTRAR Aug 15 '61				24b. REGISTRAR'S SIGNATURE Charles S. Hanna							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-28

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1805 Greenway Avenue

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1805 Greenway Avenue

9193

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09183

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>				c. LENGTH OF STAY IN lb <u>25 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Idella Hopkins</u>				4. DATE OF DEATH <u>8</u> Month <u>2</u> Day <u>1961</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 25, 1921</u>	
9. AGE (In years lost birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Mich.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Russell Garbett</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Cassidy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WW. 2</u>				16. SOCIAL SECURITY NO. <u>383-16-2596</u>		17. INFORMANT <u>Shenn W. Hopkins</u> Address <u>109 N. Post Rd. Aberdeen</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic shock</u> 576 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Abdominal perforation</u> DUE TO (c) <u>Peritonitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 da</u> <u>1 wk</u> <u>2 wk</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (1) this hospital attended the deceased from <u>7/9/61</u> to <u>8/2/61</u> 19, that (we) last saw the deceased alive on <u>8/2/61</u> 19, and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Alfred W. Grigoleit MD</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/4/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alfred W. Grigoleit MD</u>				22d. ADDRESS <u>608 S. Union Ave. Havre de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Tarring</u> ADDRESS <u>Tarring Funeral Home Aberdeen, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH

(M)

Nov. 22, 1931

E. B. 1931

100-1-1000

Yes W. S.

Chicago, Illinois

Chicago, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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9194
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
09184

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural #2</u> c. LENGTH OF STAY IN 1b <u>18 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>1 Rural #2 - Rt. #22</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rudolph Frank Horky</u>				4. DATE OF DEATH Month Day Year <u>8 28 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/5/1898</u>	
9. AGE (In years last birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR Months Days <u>8 28</u>		11. IF UNDER 24 HRS. Hours Min. <u>8 28</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouse retires Dan Company</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Czechoslovakia</u>			
11. FATHER'S NAME <u>John H. Horky</u>				12. MOTHER'S MAIDEN NAME <u>Mary Welkhus</u>			
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				14. SOCIAL SECURITY NO. <u>None</u>			
15. INFORMANT <u>J. Ralph Horky - Aberdeen #2 - Rd.</u>				16. ADDRESS			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Congestive Heart failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>500.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
19a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
20. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> to <u>8/28</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/26</u> , 19 <u>61</u> , and that death occurred at <u>7:20</u> M, from the causes and on the date stated above.							
21a. SIGNATURE <u>Dudley Phillip</u>				21b. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		21c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition <u>Burial</u>				22b. DATE THEREOF <u>8/31/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>	
23a. LOCATION (City, town or county) <u>Balto. Maryland</u>				23b. DATE <u>AUG 31 '61</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarrang - Aberdeen, Maryland</u>				25. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

A circular diagram with a central point and four radial lines extending to the circumference, dividing the circle into four equal quadrants. Each quadrant contains a percentage value: the top-left quadrant is labeled '30%', the top-right is '20%', the bottom-left is '10%', and the bottom-right is '40%'. The total '100%' is written in the center of the circle.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

9195

09185

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Street		c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Taylor Road				d. STREET ADDRESS Taylor Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY W. JORDAN				4. DATE OF DEATH August 5, 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1931		9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Radio		11. BIRTHPLACE (County & State, or foreign country) Hillsboro, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Winters Jordan				14. MOTHER'S MAIDEN NAME Georgie Morgan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Korean		16. SOCIAL SECURITY NO. 236-52-4933		17. INFORMANT Mrs. Harry W. Jordan, Street, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissiminated carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Adenocarcinoma of descending colon (multiple polypsis) DUE TO (c) no						INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct. 4 Aug 1961 , to 5 Aug 1961 , that (I) (we) last saw the deceased alive on 4 Aug 1961 , and that death occurred at 1:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE Edwin W. Whiteford, Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5 Aug 61	
22c. PHYSICIAN'S NAME (Type) Edwin W. Whiteford, Jr.				22d. ADDRESS Whiteford, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 9, 1961		23c. NAME OF CEMETERY OR CREMATORY Oak Grove		23d. LOCATION (City, town or county) (State) Hillsboro, W.Va.	
24. FUNERAL DIRECTOR'S SIGNATURE John A. Harkins				ADDRESS Delta, Penna.		25a. REC'D BY REGISTRAR DATE AUG 8 '61	
				25b. REGISTRAR'S SIGNATURE Charles S. Haines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9196

CERTIFICATE OF DEATH

Reg. Dist. No.

09186

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rocks		c. LENGTH OF STAY IN 1b 76 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rocks		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Madonna			
3. NAME OF DECEASED (Type or print) First Middle Last IDA LURETTA LEMMON				4. DATE OF DEATH Month Day Year August 22 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1885	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Jarrettsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Henry Brookhart				14. MOTHER'S MAIDEN NAME Ida Elenor Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) ---		INFORMANT Howard A. Lemmon		Address Rocks, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. Cardio-Vascular Disease DUE TO with hypertension (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Cervix Stage I							INTERVAL BETWEEN ONSET AND DEATH 3da ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1961 , to Aug 22 1961 , that I last saw the deceased alive on Aug 20, 1961 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Willard P. Hudson PHYSICIAN'S NAME (Type) Willard P. Hudson Forest Hill, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/1961		22c. NAME OF CEMETERY OR CREMATORY Bethel		22d. LOCATION (City, town, or county) (State) Madonna Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles C. Kutz				ADDRESS Jarrettsville Md.		24a. REC'D BY REGISTRAR DATE AUG 24 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kinn			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9197

CERTIFICATE OF DEATH

09187

1. PLACE OF DEATH a. COUNTY Harford MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Pylesville c. LENGTH OF STAY IN 1b 50 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Pylesville d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) MYRTLE N. LOWE			4. DATE OF DEATH Month August Day 9 Year 19 61				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1884		9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mineola, Neb.			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME J.B. Proctor				
14. MOTHER'S MAIDEN NAME Mary Whiteside			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. 220-34-6054			17. INFORMANT Clayton Lowe				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Carcinoma of ovary 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 yr				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 8, 1961 to Aug 11, 1961 , that (I) (we) last saw the deceased alive on Aug 8, 1961 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Edward W. Hyson M.D.				22b. DATE SIGNED Aug. 11, 1961			
22c. PHYSICIAN'S NAME (Type) Edward W. Hyson				22d. ADDRESS Fawn Grove, Penna.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 13, 1961		23c. NAME OF CEMETERY OR CREMATORY Friends			
23d. LOCATION (City, town or county) Fawn Grove, Penna.		(State)					
25a. REC'D BY REGISTRAR John H. Harkins				25b. REGISTRAR'S SIGNATURE Arthur E. Hume			
25c. ADDRESS Delta, Penna.				25d. DATE AUG 14 '61			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09188

9198

Item 2 Film 0294 9/7/61 1wk

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>Harford</i> STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford - Grace</i>		c. LENGTH OF STAY IN lb <i>11 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Delta 75x3</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>Harford Crescent Home</i>	
3. NAME OF DECEASED (Type or print) <i>Eugenia Carson Lucas</i>		4. DATE OF DEATH <i>8 26 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 9, 1897</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Basham</i>		14. MOTHER'S MAIDEN NAME <i>Salle Ellen Moore</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-058433</i>	
17. INFORMANT <i>Mr. Carl Edmonson / Sister</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage (Carcinoma of Colon)</i> DUE TO <i>153.8</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of Colon</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cholelithiasis; Chr Cardio-Vascular Disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 1958</i> to <i>Aug. 26, 1961</i> , that (I) (we) last saw the deceased alive on <i>Aug. 26, 1961</i> , and that death occurred at <i>6:45 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Willard P. Hudson</i> M.D.		22b. ADDRESS <i>Forest Hill, Md.</i>	
22c. PHYSICIAN'S NAME (Type) <i>WILLARD P. HUDSON</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>AUG. 29, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>DARLINGTON</i>		23d. LOCATION (City, town, or county) (State) <i>DARLINGTON, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Harkins</i> ADDRESS <i>DELTA, PA.</i>		25a. REC'D BY REGISTRAR <i>AUG 29 '61</i> DATE	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9199 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 7 Film G292 8/16/61											
1. PLACE OF DEATH a. COUNTY Harford				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Harford							
c. LENGTH OF STAY IN 1b Harford Memorial Hospital				d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)							
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Tennessee				b. COUNTY Tennessee							
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turtletown				d. STREET ADDRESS 79x-3							
3. NAME OF DECEASED (Type or print) JOHN MEALER				4. DATE OF DEATH 8 9 1961				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH March 10, 1911				9. AGE (In years last birthday) 50 yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) miner				10b. KIND OF BUSINESS OR INDUSTRY Polk Co, Tenn				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Tom Mealer				14. MOTHER'S MAIDEN NAME Carrie Yoder							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 415-05-0568				17. INFORMANT Millard Finch Funeral Home, McCaysville, Ga			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ducktown, Tenn			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. NAME OF CEMETERY OR CREMATORY Zion Hill Cemetery							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				22b. DATE THEREOF 8-10-61				22d. LOCATION (City, town, or country) (State) Ducktown, Tenn			
23. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street, Zone 2				24a. REC'D BY REGISTRAR AUG 11 '61				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

09189

8-10-61

RECEIVED
BIRMINGHAM

(M)

(1)

Hartford

State of Texas

Hartford Memorial Hospital

John A. White

John A. White

John A. White

John A. White

Intermittent cardiac murmurs

John A. White, M.D.

John A. White, M.D.

John A. White, M.D.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09190

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>anna</u> Middle <u>Keen</u> Last <u>Numbers</u>		4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/28/1868</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11c. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James MalCOLM</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Frances Clark-Perryman wid.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Ventricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart Disease</u> (c) <u>Coronary arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>10 yr.</u> <u>10 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1947</u> to <u>8-29-1961</u> , that (I) (we) lost saw the deceased alive on <u>8-28-1961</u> , and that death occurred at <u>8:20 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Peter P. Rodman</u>		22b. DATE SIGNED <u>8-30-61</u>	
22c. PHYSICIAN'S NAME <u>Peter P. Rodman, M.D.</u>		22d. ADDRESS <u>8 Law St., Aberdeen, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/1/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Shesute Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Perryman, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring - Aberdeen, Md.</u>		25. REC'D BY REGISTRAR DATE <u>SEP 5 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>			

John G. Tarring

9201

CERTIFICATE OF DEATH

Reg. Dist. No.

03191

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Jarrettsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Forest Hill</u>	
c. LENGTH OF STAY IN 1b <u>41 yrs.</u>		d. STREET ADDRESS <u>Near Jarrettsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Watters</u> Last <u>Patton</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>23</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1877</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wall Paper Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cooptown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Patton</u>		14. MOTHER'S MAIDEN NAME <u>Frances Gilbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-16-6926</u>	
17. INFORMANT <u>Howard W. Patton Jr.</u>		Address <u>Forest Hill, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardio Vascular Disease and Prostatic Hypertrophy.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 19 59</u> to <u>Aug. 23, 19 61</u> , that I last saw the deceased alive on <u>Aug. 22, 19 61</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>Aug. 24, 1961</u>			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u> <u>Forest Hill, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/26/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>William Watters</u>		22d. LOCATION (City, town, or county) (State) <u>Cooptown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kutz</u>		24. REC'D BY REGISTRAR DATE <u>AUG 28 '61</u>	
ADDRESS <u>Jarrettsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>	

MEDICAL CERTIFICATION

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

Name of Deceased [Illegible]		Sex [Illegible]	
Date of Birth [Illegible]		Place of Birth [Illegible]	
Date of Death [Illegible]		Place of Death [Illegible]	
Cause of Death [Illegible]		Manner of Death [Illegible]	
Name of Physician [Illegible]		Name of Undertaker [Illegible]	
Name of Burial Place [Illegible]		Name of Cemetery [Illegible]	
Name of Minister of Religion [Illegible]		Name of Funeral Home [Illegible]	
Name of Coroner [Illegible]		Name of Jury [Illegible]	
Name of Registrar [Illegible]		Name of Clerk [Illegible]	

W

I

This is to certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Wyoming, at Cheyenne, Wyoming, on the [illegible] day of [illegible], 1901.
 [Illegible Signature]
 Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9202

CERTIFICATE OF DEATH

Reg. Dist. No.

09192

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pylesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Pylesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pylesville, R.D.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles B. Richardson</u>		4. DATE OF DEATH Month Day Year <u>August 27 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Calvin Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Wiley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>220-34-519</u>	
17. INFORMANT <u>William Richardson</u>		Address <u>Pylesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic C-V Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>61</u> , to <u>Aug. 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug. 20</u> , 19 <u>61</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph G. Hunt M.D.</u>		ADDRESS (Street, city or town, state) <u>Delta Pa.</u>	
PHYSICIAN'S NAME (Type) <u>Joseph G. Hunt M.D.</u>		DATE SIGNED <u>8-28-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 30, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Highland Presby. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Street, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Orshum</u>		24a. REC'D BY REGISTRAR <u>Stewartstown Pa.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>		DATE <u>AUG 31 '61</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9203

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09193

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAVRE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAVRE DE GRACE X			
c. LENGTH OF STAY IN 1b LIFE				d. STREET ADDRESS RD #2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RD #2				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVA Middle MAE Last RINEER				4. DATE OF DEATH Month AUG. Day 15 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 23, 1879	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME			
11. BIRTHPLACE (State or foreign country) MD				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME GEORGE HARRISON BOWMAN				14. MOTHER'S MAIDEN NAME HARRIET A. EVANS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. —			
17. INFORMANT MRS LINDA R. FENBY, HAVRE DE GRACE, MD				Address —			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY INFARCTION DUE TO 900.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) FRACTURE OF RT. FEMOR (NECK) + 1 MONTH (c) PELVIS							INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 186 - FELL DOWN ON STEPS AT HOME					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/14 19 61 to 8/15 19 61 , that (I) (we) last saw the deceased alive on 8/14 19 61 , and that death occurred at 11:20 A.M. from the causes and on the date stated above.							
22a. SIGNATURE John D. Yun				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN D. YUN, MD				22d. ADDRESS 615 S. UNION AVE, HAVRE DE GRACE			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug. 18, 1961		23c. NAME OF CEMETERY OR CREMATORY WEST NOTTINGHAM CEM. CECIL CO.		23d. LOCATION (City, town, or county) (State) MD	
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell				25a. REGISTRY REGISTRAR Aug 21 61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

(M)

2503

CERTIFICATE OF DEATH

MAILED AT DEATH OF HEAL
WHICH IS BEING SENT TO THE
FAMILY OF DECEASED

NO. 2503

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
DATE OF DEATH
PLACE OF BIRTH
PLACE OF DEATH
CAUSE OF DEATH
DISEASE
SIGNATURE OF DECEASED
SIGNATURE OF WITNESSES
SIGNATURE OF MINISTER OF HEALTH
SIGNATURE OF REGISTRAR
SIGNATURE OF CLERK

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9204

CERTIFICATE OF DEATH

09194

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> c. LENGTH OF STAY IN 1b <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> d. STREET ADDRESS <u>1116 S. Washington St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Esther O'Neill Smith</u>		4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 3, 1893</u>		9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - LIBRARIAN - A.P. B.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Walter T. Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Nellie (Moore) Jackson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war and dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. Raymond Colburn</u> Address <u>Havre de Grace, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete Muscular Paralysis</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Debility - Exhaustion</u> DUE TO <u> </u> (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>											
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> to <u>8-9</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.															
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u> </u>				22c. PHYSICIAN'S NAME (Type) <u> </u>				22d. ADDRESS <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>AUG. 12, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cem.</u>				23d. LOCATION (City, town or county) <u>HAVRE DE GRACE, MD</u> (State) <u>MD</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>HAVRE DE GRACE, MD</u>				25a. REC'D BY REGISTRAR <u>AUG 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

VR A15 (4)
 15M 9/60



2502

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9205
CERTIFICATE OF DEATH

Reg. Dist. No.

09195

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 2, Bel Air (Rural)				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fountain Green Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle D. Last Stamper				4. DATE OF DEATH Month August Day 1 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1878	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Gen. Store			10b. KIND OF BUSINESS OR INDUSTRY Retail Business		11. BIRTHPLACE (State or foreign country) Laurel Springs, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alex Wagoner			14. MOTHER'S MAIDEN NAME Clementine Stamper				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-32-3186		INFORMANT Address John H. Stamper Rt. 2, Bel Air, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis : Second Attack 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardio Vascular Disease. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 5 days ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March , 19 47 , to Aug. 1 , 19 61 , that I last saw the deceased alive on July 31 , 19 61 , and that death occurred on 11:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED August 2, 1961							
ACTUAL SIGNATURE Willard P. Hudson M.D. Forest Hill, Md. August 2, 1961							
PHYSICIAN'S NAME (Type) WILLARD P. HUDSON M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Aug. 4, 1961		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster W. Broadway + Williams St BEL Air, Maryland				24a. REC'D BY REGISTRAR DATE AUG 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Joseph W. Foster

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

CERTIFICATE OF EVIDENCE

2005

IN RE: [illegible]
[illegible]

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[illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9206											
CERTIFICATE OF DEATH											
09196											
1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE c. LENGTH OF STAY IN 1b 12 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD MEMORIAL HOSP.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND f. COUNTY HARFORD c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Abingdon d. STREET ADDRESS HOOKER Mill Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ARTHUR G Stansbury						4. DATE OF DEATH August 13 19 61					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 29, 1909		9. AGE (In years, last birthday) 51		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor				10b. KIND OF BUSINESS OR INDUSTRY Oil		11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HOWARD R. Stansbury						14. MOTHER'S MAIDEN NAME ADA MAE GREEN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-07-6683				17. INFORMANT Robert L. Stansbury, Callaway Maryland.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive anterior myocardial infarction 12 days 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis 12 days (c) Coronary arteriosclerosis ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Aug 1st, 1961 to Aug 13th 1961 that (I) (we) last saw the deceased alive on Aug 13th 1961 , and that death occurred at 4:00 PM , from the causes and on the date stated above.											
22a. SIGNATURE Edward C. Loo, M.D. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 8/14/61											
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D. 22d. ADDRESS 211 N. Union Ave. Haure de Grace Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Aug 16, 1961 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn 23d. LOCATION (City, town or county) (State) Baltimore Maryland.											
24. FUNERAL DIRECTOR'S SIGNATURE Howard R. Stansbury ADDRESS Abingdon, Maryland. 25a. REC'D BY REGISTRAR DATE AUG 18 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kenna											

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SECTION 2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
9207										
CERTIFICATE OF DEATH										
09197										
1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY CECIL					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER*deGRACE			c. LENGTH OF STAY IN lb 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT			RURAL		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.					d. STREET ADDRESS 07X-2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last ELMER CLARENCE STUMP					4. DATE OF DEATH Month Day Year 8/ 24/ 1961					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/31/ 1893		9. AGE (In years last birthday) 67 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER RET.			10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED PA.			11. BIRTHPLACE (State or foreign country) U.S.A.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN					14. MOTHER'S MAIDEN NAME KATHERINE STUMP					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 189-07-7938			17. INFORMANT Address MRS. ELMER STUMP PORT DEPOSIT, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6 19 61 , to 8/24 19 61 , that (I) (we) lost saw the deceased alive on 8/24 19 61 , and that death occurred at 80 M, from the causes and on the date stated above.										
22a. SIGNATURE Neil Taylor					22b. ADDRESS Rising Sun, Md.					
22c. PHYSICIAN'S NAME (Type) Neil Taylor Jr MD					22d. ADDRESS Rising Sun, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8/28/1961		23c. NAME OF CEMETERY OR CREMATORY BROOKVIEW CEM.		23d. LOCATION (City, town, or county) (State) RISING SUN, MD.			
24. FUNERAL DIRECTOR'S SIGNATURE Thomas M. Mullen					25a. RECEIVED BY REGISTRAR DATE AUG 29 1961		25b. REGISTRAR'S SIGNATURE Arthur S. K...			

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HARFORD

HARFORD-DECKARD

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PORT DEPOSIT

HARFORD MEMORIAL HOSP.

ELMER

CLAMMACK

STUMP

MALE WHITE

8/31/1893

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EST. SUE EMPLOYED FA.

UNKNOWN

KATHLEEN

STUMP

NO

189-07-2938 MRS. ELMER STUMP

PORT DEPOSIT, MD.

8/28/1961

BROOKVIEW CEM.

RISSING ST.

RISSING ST., MD.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10286 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12703									
Item 9 Film G30-12/4/61-jwk									
1. PLACE OF DEATH a. COUNTY <i>Harford</i>					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Unknown</i> b. COUNTY <i>Unknown</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Joppa</i>					c. LENGTH OF STAY IN 1b <i>Unknown</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>US Route 40</i>					d. STREET ADDRESS <i>Unknown</i>				
3. NAME OF DECEASED (Type or print) <i>Unknown</i>					4. DATE OF DEATH <i>August 10 1961</i>				
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>?</i>		9. AGE (In years last birthday) <i>60 approx.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY <i>?</i>			
13. FATHER'S NAME <i>Unknown</i>					14. MOTHER'S MAIDEN NAME <i>Unknown</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>?</i>					16. SOCIAL SECURITY NO. <i>?</i>				
17. INFORMANT <i>Wife</i>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture skull</i> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture R femur</i> <i>Auto accident</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i>				
20c. TIME OF INJURY Month, Day, Year Hour <i>8-9</i> 19 <i>61</i> p.m. <i>7</i>					20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>US Route 40</i>					20f. (City or town) <i>Joppa</i> (County) <i>Harford</i> (State) <i>Md.</i>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Gerald C Palmer</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> 8-10-61				
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>Bel Air, Md.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					22b. DATE THEREOF <i>Nov. 16, 1961</i>				
22c. NAME OF CEMETERY OR CREMATORY <i>County Home</i>					22d. LOCATION (City, town, or country) (State) <i>Bel Air, Harford, Maryland</i>				
23. FUNERAL DIRECTOR <i>Howard K. McComas & Son</i>					24a. REC'D BY REGISTRAR <i>Howard K. McComas</i>				
ADDRESS <i>Abingdon, Md.</i>					24b. REGISTRAR'S SIGNATURE <i>Howard K. McComas</i>				
DATE NOV 20 '61									

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "A. D. 1870" and "S. D. 1870" are faintly visible.]

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9208

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09198

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>1 DAY</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>601 GREEN ST.</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>GARDNER WILLIAM VAN EVERA</u>				4. DATE OF DEATH Month Day Year <u>August 24 1961</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 27, 1900</u>			
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WRITER & SERVICE ENG.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GLEN L. MARTIN</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>HARRY VAN EVERA</u>				14. MOTHER'S MAIDEN NAME <u>BERTHA MOYER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>WORLD WAR I</u>				16. SOCIAL SECURITY NO. <u>215-12-3707</u>		17. INFORMANT Address <u>Mrs. Sue M. VAN EVERA, HAVRE DE GRACE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HT. of lung</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____								INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 3</u> 19 <u>61</u> to <u>Aug 24</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 24</u> 19 <u>61</u> and that death occurred at <u>12:10</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS _____					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG 27 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM</u>		23d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>MD. HAVRE DE GRACE</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

(M)

208

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of Funeral Director

Signature of Burial Director

Signature of Cemetery Director

Signature of Interment Director

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9209

CERTIFICATE OF DEATH

Reg. Dist. No. 08199

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BEL AIR</u>		c. LENGTH OF STAY IN lb <u>25 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>GILMORE</u> Middle <u>WEEMS</u> Last		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 24, 1892</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-empl. plumber</u>	
11. BIRTHPLACE (State or foreign country) <u>COLORADO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Henry Weems</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES SINGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>218-32-1342</u>	
17. INFORMANT <u>Mrs. Marjorie Weems</u> (wife) Address <u>RD#2, BEL AIR, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Hemorrhage from Naso-pharynx</u> <u>146X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA of Naso-pharynx</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>December</u> , 19 <u>53</u> , to <u>August 17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>August 17</u> , 19 <u>61</u> , and that death occurred at <u>11:30P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul S. Stonesifer Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>115 FULFORD Ave</u> DATE SIGNED <u>8/17/61</u>	
PHYSICIAN'S NAME (Type) <u>PAUL S. STONESIFER JR.</u>		<u>BEL AIR, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/20/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u> ADDRESS <u>Tarring Funeral Home Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 22 '61</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hanna</u>	

MEDICAL CERTIFICATION

PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the physician or attending physician. TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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09200

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b <u>12 3/4 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosalie</u> Middle <u>Fear</u> Last <u>Welch</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 16, 1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Boston Fear</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth (maiden name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Paul Hastings, Jr., Bel Air, Md., R.F.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> <u>156.1</u> DUE TO <u>Ca. of the liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>A.S.C.V.D.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/4</u> 19 <u>61</u> , to <u>8/5</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 5</u> 19 <u>61</u> , and that death occurred at <u>8:15</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loo, M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>Aug 5 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				22d. ADDRESS <u>Harre de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 8, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Concord Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Near Federalburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hampton Funeral Home Federalburg Md.</u> ADDRESS <u> </u>				25a. REC'D BY REGISTRAR <u>Aug 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Anthony S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ESTIMATE OF DEATH

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NAME OF DECEASED: J. H. H. H.

DATE OF DEATH: 11/11/11

PLACE OF DEATH: 1110

CAUSE OF DEATH: 1110

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